NEW PATIENT ORIENTATION PACKET

Welcome to
Family Medical Care of Lawrence County

The mission of Family Medical Care of Lawrence County is to serve our community by providing quality whole person health care in a Christ-like environment.

Enclosed you will find the following forms: medical history, request for disclosing verbal information, records release and financial policy. To ensure we can effectively make your new patient visit a pleasant experience, please complete these forms and return them to us before your scheduled appointment day.

Thank you in advance for your kind attention to these forms.

PATIENT INFORMATION

Office location: 150 N. New Castle Street, New Wilmington, PA 16142
Telephone: 724.946.3564
Fax: 724.946.2156

Appointments

All patients will receive access to appropriate medical care within a reasonable length of time. Appointments will be made according to the type of appointment needed. If you are more than 15 minutes late for your appointment, you may be asked to see another one of our providers or reschedule.

If you are unable to keep a scheduled appointment, we ask that you kindly call the office 24 hours in advance to cancel. If you fail to call *or* contact us via the patient portal, you will be marked as a 'No Show'. Our 'No Show' policy is as follows: you will be contacted by phone after your first offense. After the second occurrence, you will receive a phone call and letter. Upon the third 'No Show', you may be dismissed from the practice. If you fail to show for your new patient appointment, you may be rescheduled at the discretion of the practice.

Emergencies

You will be seen in our office by a provider that is available or a clinical staff member; unless the provider feels the hospital ER is more appropriate, i.e. severe trauma, severe bleeding, seizures, chest pain, shortness of breath, etc.

Urgent

You will be seen within 24-48 hours of calling with conditions such as high fever, animal bite, severe pain, etc. Kindly call to schedule an appointment as early in the day as possible or as soon as symptoms begin.

Routine Care

Depending on the type of appointment needed, i.e. regular follow-up, consultation, pap smear, physical, etc. you may be scheduled within two weeks to two months of your call. Please provide us with information about whether your insurance pays for "well visits" or "preventative care" at the time of service.

Walk-Ins

We strongly urge all patients to call the office first in order that we may check availability for that day. If all providers are booked and it is not an emergency, you may be asked to schedule an appointment.

After-Hours

We have a physician on call, 24 hours a day, to provide emergency and urgent medical needs. Please call the office at **724.946.3564** and follow the instructions given.

Payments/Co-pays

Co-pays are expected at the time of service. We accept Visa, Master Card, bank cards, checks, and cash for payments.

Medication

Kindly bring all your current medications with you to each visit (prescription, over-the-counter and/or supplements). You should ask for refills, if needed, at each visit. If you require refills outside of an appointment we ask that you contact your pharmacy who will then send us a message electronically.

PLEASE NOTE* Due to the increasing prescription drug problem, we will NOT prescribe any controlled substances at your **first** visit. This includes narcotic pain medication, anxiety medication or ADHD medication. Also, we do NOT provide chronic pain management but will assist you with a referral to a pain clinic, if necessary.

No prescription refills can be done on the weekends, holidays or after office hours, unless it is an emergency.

If you are overdue for a follow-up visit, refills may be given for a 30-day supply only. An appointment must be scheduled for you to see the provider within that 30-day time period.

Test Results

Please allow 3-5 days before calling the office for your test results. If a provider outside our group orders a test, you will need to call that office for the results.

Fees and Insurance

One of the goals of our practice is to keep the cost of our medical care as low as possible. In order to do this, we ask that you adhere to the following:

- Co-pays, deductible amounts, and any balances from previous visits are due at the time of service.
- Uninsured patients please see the Self-Pay section below.
- Present your insurance card at each visit and update your personal information (address, phone number, etc) as soon as there is a change.

As a courtesy to you, we will bill your insurance. We will assist you in any way we can to use benefits to which you are entitled. However, the ultimate responsibility for payment and providing accurate information about your insurance is yours.

We must note that insurance coverage for many policies is changing rapidly, and we cannot guarantee that all services you receive at your visit will be covered. We will submit all charges to your insurance and they will determine if there is any financial responsibility on your part. When we are notified by your insurance of any amount you owe, we will send you a statement. If special financial arrangements need to be made, please contact our billing department.

Self-Pay Patients

Estimated charges for your visit with one of our providers will be determined at the time of checkout. You will be offered a self-pay discount if paid in full at check out. If there are any additional charges based on your type of visit you will be sent a statement for additional payment. (You will be offered the same discount you were given at the time of your visit). If you have any questions, please call our office and ask to speak with the billing department.

MEDICAL HISTORY FORM

Name:_________________________________ SSN:____________________

Birth Date:____/____/_____ Male____ Female____

Address:____

Phone: ( )____________________ Cell: ( )___________________

Work: ( )_____________________

Please list any allergies to medications, x-rays dyes, latex, adhesive tape, bees, foods, hay fever, or any other substances and explain reaction: _____________________________________

____

Please list all prescribed and over-the-counter medications that you are currently taking.

Medication Name	Dosage & Directions	Approx years	Prescribing Doctor

Please list any over-the-counter vitamins/supplements that you are currently taking:

____

____

Health Maintenance – Please write the date of your last:	
Bone Density Test:	Physical Exam:
Chest X-Ray:	Mammogram:
Cholesterol Check:	Prostate Exam:
Colonoscopy:	PSA:
EKG:	Stress Test:
Eye Exam:	Urinalysis:
Pap Smear:	HgbA1C:

Health Maintenance (Vaccinations) - Please write the date and type of your last:	
Pneumonia Vaccine:	Other:
Tetanus Immunization:	
Flu Vaccine:	
Shingles Vaccine:	

Please check all that apply:

Childhood Illnesses/Diseases					
	ADHD		Diphtheria		Pneumonia
	Acne		Ear Infection		Poliomyelitis
	Asthma		Measles		Rheumatic Fever
	Atrial Flutter		Meningitis		Rubella
	Cerebral Palsy		Mononucleosis		Scarlet Fever
	Chicken Pox		Mumps		Strep Throat
	Frequent Colds		Pertussis		

Please list any surgeries you have had:

Type of Surgery	Date	Surgeon	Hospital/Facility

Please list any hospitalizations you have had:

Hospitalizations	Reason/Diagnosis	Date

Please check all that apply:

Medical History (Current and Past Medical Conditions)			
	Aids		Hypothyroidism
	Alcoholism		Kidney Disease
	Alzheimer's Disease		MRSA
	Anxiety		Multiple Sclerosis
	Arthritis		Osteoporosis/Osteoarthritis
	Asthma		Parkinson's Disease
	Atrial Fibrillation		Pneumonia
	C-Diff		Seizure Disorder
	Congestive Heart Failure		Sleep Apnea

Medical History (Current and Past Medical Conditions)			
	Coronary Artery Disease		Stroke
	Deep Vein Thrombosis		TIA
	Depression		Ulcer
	Diabetes Type I		Cancer/Type:
	Diabetes Type II		
	Enlarged Prostate		Back Problems/Type:
	GERD/Acid Reflux		
	Gout		Colon Problems/Disease/Type:
	Heart Attack/Year:		
	High Blood Pressure		Other:
	High Cholesterol		

FAMILY HISTORY

Relation	Health Problems/Diseases/Conditions
Mother *Deceased ☐ If yes, age at time of death___*	
Father *Deceased ☐ If yes, age at time of death___*	
Children *Number_______*	
Siblings *Number ______*	
Maternal Grandmother	
Maternal Grandfather	
Paternal Grandmother	
Paternal Grandfather	

SOCIAL HISTORY

Marital Status: Single__ Married__ Divorced__ Widowed__ Separated__

Highest level of education completed:_______________ Occupation:____________

Do you have a Living Will/Advanced Directive? Yes___ No___

Tobacco Use: Never__ Cigarettes__ Cigars__

Number of packs a day:__________ Year quit:__________

Smokeless Tobacco (Chew): Yes__ No__ Year quit:__________

Alcohol Use: Never__ Rare__ Occasional__ Frequent__

Number of drinks per day:________

Drug Use: No__ Yes__ If *yes*, please explain:____________________________________

Caffeine use: Never__ Rare__ Occasional__ Frequent__

Chocolate: Never__ Rare__ Occasional__ Frequent__

Exercise: Times per week____ Daily____ Sporadically____ Not Exercising____

"Care Team" - Please list other physicians/physician groups you see:

Physician Name	Physician Name
Eye Doctor:	Dentist:
Orthopedic Surgeon:	Pulmonologist:
ENT:	OB/Gyn:
Cardiologist:	Pain Specialist:
Oncologist:	Podiatrist:
Urologist:	Other:

Family Medical Care of Lawrence Co.

150 N New Castle Street
New Wilmington, PA 16142
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Fax: 724-946-2156

AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

This authorization gives Family Medical Care of Lawrence County permission to use and/or disclose health information about you.

Patient Name: (Print)____

Birth Date:____________ Address:____

Furnish records to: Family Medical Care, 150 N New Castle St, New Wilmington, PA 16142
Obtain records from:
Name of Provider/Facility____

Address____

Phone_____________________________________Fax_______________________________

Specific description of information to be used or disclosed:
____

Dates of Service:____
Purpose of disclosure:____
If you are transferring, kindly indicate reason for transfer:______________________________

*Right not to sign. You may refuse to sign this authorization. Refusal to sign this authorization will not affect your ability to obtain treatment by FMC, except in the case of health care that is solely for the purpose of creating health care information for disclosure to a third party (pre-employment physical, life insurance physical, life insurance physical, research related care).

*Right to revoke. You may revoke this authorization, in writing, at any time by sending written notification to: Family Medical Care, Attn: Office Manager; 150 N New Castle St New Wilmington, PA 16142

I understand that a revocation is not effective to the extent that the provider has relied on the use or disclosure of the protected health information.
Re-disclosure. Health information disclosed pursuant to this authorization may be subject to re-disclosure because it is no longer protected by the federal privacy rule or another privacy law.
Inspect/Copy. You have the right to inspect or copy the protected health information to be used or disclosed.

This authorization shall remain in effect from the date signed below for 90 days.

____ ______________________
Signature of Patient or Personal Representative Date

____ ______________________

Print Name of Personal Representative   Relationship to Patient

SPECIAL AUTHORIZATION

SPECIAL AUTHORIZATION IS REQUESTED FOR RELEASE OF HIV INFORMATION YOUR SIGNATURE IS REQUIRED IN THE SPECIAL AUTHORIZATION AREA FOR THESE RECORDS

HIV RECORDS RELEASE AUTHORIZATION

My HIV records may be released to the recipient noted on this form.

PATIENT SIGNATURE____DATE__________

The patient named above is unable to provide a signature due to:________________________

PARENT/LEGAL GUARDIAN SIGNATURE___________________________DATE__________
Relationship to Patient____
Address____

This consent will be valid beginning on _____/_____/______ and will expire after 30 days, if not revoked earlier or____
(list any specific events or conditions) any may be revoked at any time unless relied upon.

I understand that my consent is subject to my revocation at any time, except to the extent that the person to whom this disclosure has been made has already acted in reliance on it.

The following statement will be attached to the record requested: This information has been disclosed to you from records protected by Pennsylvania Law. Pennsylvania Law prohibits you from making any further disclosures of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is authorized by the Confidentiality of HIV-Related Information Act. A general authorization for release of medical or other information is not sufficient for this purpose.

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FINANCIAL RESPONSIBILITY FORM

Thank you for choosing us as your health care provider. We are committed to providing you with quality and affordable healthcare. The following financial policies have been established to avert payment and insurance issues. Your signature below confirms that you have read and will comply with the policy. A copy will be provided to you at your request.

***Information**: We ask that you present your insurance card to us at every visit as proof of current insurance coverage. We will also ask you to verify your current home address and phone number. If we do not have accurate information to bill for the services you receive during your visit with us, *you may be responsible for payment of all services provided*.

***Co-Payments**: Your insurance company requires us to collect co-payments at the time of service. Waiver of co-payments may constitute fraud under state and federal law. Please help us in upholding the law by paying your co-payment at each visit. *If you schedule an appointment for a "Physical" and other problems are addressed during that same visit, you may be charged an additional co-pay.*

***Non-covered services**: You should be aware that some, or perhaps all of the services you receive may be non-covered or not considered reasonable or necessary by your insurance provider. You will be responsible for these services in full.

***Non-payment**: Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice.

***Missed Appointments**: If you are unable to keep your appointment, we ask that you kindly call our office at least 24 hours prior to your scheduled time. You may be charged a $20.00 fee if you miss your appointment without notifying our office. These charges will be your responsibility and billed directly to you. After three such missed appointments you may be discharged from this practice. Please help us to serve you better by keeping your regularly scheduled appointments or timely canceling them.

***Form Completions**: Kindly allow up to two weeks for ALL forms to be completed. We will try to complete all forms in a timely fashion but ask for your patience. There may be a fee for completion of the form based on type and complexity. Our practice is committed to providing the best care to our patients. Thank you for understanding our payment policies. If you have any questions please contact us.

I have read and understand the above payment policy and agree to abide by its guidelines.

PRINTED NAME____ DOB_______________

SIGNATURE____DATE_______________

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PATIENT REQUEST FOR DISCLOSING VERBAL INFORMATION

PATIENT NAME:_______________________________
DATE OF BIRTH____________

I DO _____ I DO NOT _____ consent for detailed messages to be left on my voicemail.

PHONE:_______________________________________

Please list any person(s) with whom you allow this office to discuss your medical care (i.e. parents/spouse/children, etc).

Name:____________________________Relation:___________Phone:______________

Name:____________________________Relation:___________Phone:______________

Name:____________________________Relation:___________Phone:______________

Name:____________________________Relation:___________Phone:______________

Special Instructions or Limitations:____

As an extra measure of security, before any member of our office staff will discuss any aspect of your care with you or any person listed above, you or that person must know the unique password that you create with this office. Please choose any word that is easy to remember for you and the listed members. For example: pet's name, favorite vacation, favorite food, favorite color; etc. ***Be sure to notify all person's listed above of your password.

Secure Password:____

Password Hint:____

We will continue to rely on the information on this form when communicating with family members/others involved in your care, unless you request changes. Please promptly notify our office in writing if you wish to alter the designations above.

____ _________________
Signature of Patient/Legal Representative Date

____
Relationship to Patient